BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

PAUL VILJA, Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DEMO-02-0001 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair, and RENÉ EWING, Member. The hearing was held at Western State Hospital in Tacoma, Washington, on December 13, 2002. GERALD L. MORGEN, Vice Chair, did not participate in the hearing or in the decision in this matter.

1.2 **Appearances.** Appellant Paul Vilja was present and was represented by Rebecca Jones Garcia, Attorney at Law. Anne O. Shaw, Assistant Attorney General, represented Respondent Department of Social and Health Services.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of a demotion for neglect of duty, gross misconduct and willful violation of published employing agency or department of personnel rules or regulations. Respondent alleges that Appellant failed to fulfill his supervisory duties by not making frequent rounds on his ward and failed to provide appropriate direction to staff, which resulted in a patient being left in seclusion without medication and in his own urine for an eight hour period.

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504
(360) 586-1481

1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

II. FINDINGS OF FACT

2.1 Appellant Paul Vilja is a Registered Nurse (RN) 2 and permanent employee for Respondent Department of Social and Health Services (DSHS) at Western State Hospital. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on January 10, 2002.

2.2 By letter dated December 18, 2001, Chief Executive Officer C. Jan Gregg notified Appellant of his demotion from Registered Nurse 3 to Registered Nurse 2, effective January 16, 2002, for neglect of duty, gross misconduct, and willful violation of published employing agency or department of personnel rules and regulations. Ms. Gregg alleged that on September 26, 2001, Appellant failed to fulfill his supervisory duties by not making frequent rounds on his ward and failed to provide appropriate direction to staff, which resulted in a patient being left in seclusion without medication and in his own urine for an eight hour period. Ms. Gregg alleged that Appellant failed to ensure that his subordinates used sound judgment in their care of Patient T.W. and failed to intervene with T.W.'s care in order to ensure his basic needs were met.

2.3 At the outset of the hearing, the parties stipulated to the following facts:

- Patient T.W. was placed in seclusion at 2 p.m. on the afternoon of September 26, 2001.

- Appellant and his staff began working the swing shift at approximately 3 p.m. There were six employees working that swing shift.

- Appellant was the first-line supervisor for the swing shift that occurred between 3 p.m. and 11 p.m.

- Dr. Hill checked on Patient T.W. at 3 p.m., and he ordered that Patient T.W. remain in seclusion for another four hours.

- Patient T.W. urinated on the floor and on the door of the seclusion room on at least two occasions: at approximately 4 p.m. and at approximately 7 p.m.

- The mental health technicians wiped up the urine seeping out from under the door on at least two occasions.

- Throughout the shift, Patient T.W. was agitated and paced around, and he threatened staff when approached in the seclusion room. Otherwise, he was standing or sitting near the bed mumbling to himself or was relatively quiet.

- Staff offered Patient T.W. food, water, medication and bathroom privileges. However, Patient T.W. refused these offers and as a result did not receive food, water, medication or bathroom privileges during the entire swing shift.

- Cindy Brown, RN 2, was working the swing shift and had concerns that staff could get hurt by going into the seclusion room while Patient T.W. was agitated or acting in threatening manner. That is the reason that staff did not go into the room.

- Appellant did not see Patient T.W. in seclusion during the entire swing shift.

- The night shift came on at 11 p.m.

- Greg Molgaard was the first-line supervisor for the night shift from 11 p.m. to 7 a.m.

- Nightshift RN 2 Debbie Gooder check on Patient T.W. at 11:15 pm. She discovered that T.W. was standing barefoot in his urine, and she became concerned and found that his safety and hygiene were jeopardized.

- RN 2 Debbie Gooder called Greg Molgaard the RN 3 on the night shift (also the officer for the day) for intervention.

2.4 Appellant has been employed with DSHS since July 5, 1983. Appellant worked as a Registered Nurse (RN) 3 since 1986. Appellant has no history of corrective or disciplinary actions. However, Appellant's performance evaluations addressed his need to spend more time on his assigned wards assessing the care his subordinate staff gave to patients. In addition, his performance evaluations noted that he needed to concentrate on getting written reports done in a timely manner.

2.5 At the time of the incident giving rise to this appeal, Appellant worked in the Adult Psychiatric Unit (APU) of WSH. Appellant was a first-line supervisor on swing shift and was responsible for overseeing all activities on his assigned wards during his shift, including overseeing the care given to patients. Appellant was aware of agency policies and expectations, including the expectations for a RN 3 in the APU, which states as follows:

> Since RN3s are part of the ward coverage, you are expected to spend 80% of your time on the wards which you cover. RN3s covering more than one ward will spend 40% of their time on each ward. Of course staffing and your assessment of clinical need will change these percentages. . . .

2.6 On September 26, 2001, Appellant's assignment included Ward C-1 of the APU. Appellant admits that on September 26, 2001, he did not spend any time on his assigned wards. Instead, Appellant spent his time in the office completing paperwork.

2.7 RN 2 Cindy Brown was assigned to Ward C-1. Appellant was her direct supervisor. Ms. Brown was an experienced nurse, and Appellant had confidence in her ability to use good judgment and provide appropriate care to the patients on the ward.

2.8 On September 26, 2001, T.W. was a patient on Ward C-1. Ms. Brown had contact with Appellant at the beginning of the swing shift. However, they did not discuss patient T.W.

2.9 Appellant was available by telephone throughout the swing shift if Ms. Brown had needed to contact him. Furthermore, he could have been on the ward in a matter of minutes if necessary. Ms. Brown did not telephone Appellant or request his assistance with patient T.W. at any time during her shift on September 26, 2001. Therefore, Appellant was not aware of any problems or concerns regarding T.W.'s seclusion.

2.10 Debbie Gooder was the RN 2 on the night shift, and she began work at 11 p.m. At 11:15 p.m., Ms. Gooder observed patient T.W. in the seclusion room. Ms. Gooder became concerned with T.W.'s safety and hygiene when she observed that T.W. had urinated on the floor and was standing barefoot in his own urine. Ms. Gooder immediately contacted her supervisor, RN 3 Greg Molgaard, and reported her concerns regarding T.W. At approximately 11:40 p.m., Mr. Molgaard, Ms. Gooder and other staff entered patient T.W.'s seclusion room, administered prescribed medication to T.W., and cleaned the urine from the floor and from T.W.'s feet.

2.11 Ms. Gooder and Mr. Molgaard completed an Administrative Report of Incident form regarding the care that the swing shift staff provided to T.W. Anne Jones, RN 4 investigated the incident. During the fact-finding process, Ms. Jones interviewed Appellant.

2.12 On October 9, 2001, Ms. Jones initiated a Conduct Investigation Report (CIR) against Appellant. Ms. Jones alleged that Appellant "failed to fully supervise, direct, and intervene with staff when patient T.W. was left in seclusion . . . for the entire swing shift . . . without taking care of his basic needs. . . . As a supervisor, you did not make appropriate rounds or checks of the ward which would have made you aware of this incident with an opportunity to intervene on the patient's behalf. As a supervisor, you did not appropriately question the actions of your subordinates in relation to this incident."

2.13 During the CIR process, Labor Relations Officer Rick Hall conducted the administrative review. He met with Appellant and his representative. Mr. Hall admittedly became frustrated, upset, raised his voice during the meeting, and ended the meeting abruptly. Mr. Hall felt that Appellant was not addressing his questions but instead kept raising issues that were not relevant to the CIR. Mr. Hall found that Appellant did not make his rounds on September 26 and concluded that Appellant failed to perform his supervisory responsibilities.

2.14 DSHS policies prohibit abuse of patients and require staff to abide by professional and ethical standards of conduct. In addition, WSH Nursing Services Standard Policy 106, directs nursing staff to "conduct themselves in a manner which maintains a good role model for others and is conducive to maintaining a therapeutic environment for patients. . . ."

2.15 Western State Hospital Policy 3.1.1 sets forth employees' rights and responsibilities and states, in relevant part, that employees are expected:

1. To perform assigned duties with sufficient attention to achieve performance expectations.
2. To work efficiently and economically in the use of state resources.
3. To maintain and demonstrate competency in the efficient and effective performance of assigned duties.

. . . .

7. To maintain personal conduct within accepted standards of behavior.
8. To work in accordance with the published directives of Western State Hospital and the Washington State Department of Personnel.

2.16 The results of the CIR were provided to Chief Executive Officer C. Jan Gregg. Ms. Gregg reviewed the CIR report, T.W.'s patient chart, the fact-finding conclusions, and Appellant's personnel file. In addition, she discussed the incident with nurse managers. Ms. Gregg concluded

that misconduct occurred, that Appellant failed to perform his supervisory duties, and that he failed to fulfill the RN 3 nursing expectation to conduct rounds on his assigned wards. Ms. Gregg felt that if Appellant had been on the ward performing his rounds, he could have been a good role model to his staff by observing T.W. and raising staff awareness of the safety and hygiene concerns related to T.W.'s seclusion.

2.17 Ms. Gregg found that Appellant violated the public trust by not assessing T.W., not providing direction to his subordinate nursing staff, and by failing to ensure that T.W. received proper care. Ms. Gregg determined that Appellant's actions violated agency and WSH policies and nursing standards and concluded that he could no longer function effectively in a supervisory capacity. Ms. Gregg did not have any concerns regarding Appellant's clinical ability and nursing skills. Therefore, Ms. Gregg concluded that a demotion to a nursing position with no supervisory responsibilities was the appropriate discipline. By letter dated December 18, 2001, she informed Appellant of his demotion to RN 2.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant neglected his duty to supervise staff on September 26, 2001, which resulted in neglect of patient T.W. Respondent contends that because Appellant did not make his rounds on the ward, he failed to ensure that staff met patient needs and failed to ensure that nursing staff used sound judgment and provide patients with a safe environment. Respondent argues that Appellant's actions constituted gross misconduct and violated the trust the agency places in its employees and the trust the public places in the staff. Respondent further argues that Appellant's actions were deliberate, willful and were in wanton disregard of his RN 3 responsibilities. Respondent asserts that Appellant willfully violated agency policies, nursing

standards and expectations and that he could no longer be trusted to function in a supervisory role. Therefore, Respondent contends that demotion was the appropriate sanction.

3.2 Appellant argues that the nursing staff followed the appropriate seclusion protocols and that they used their clinical judgment to determine the best approach to provide care to patient T.W. in light of his history of threatening and combative behavior. Appellant admits that on September 26, 2001, he did not make his rounds and he acknowledges that he had an obligation to oversee the work of his staff. However, Appellant argues that his staff had an obligation to apprise him of any concerns or problems with patients. Appellant asserts that he was available to staff by telephone or pager and that no staff contacted him about patient T.W. Appellant argues that in his twenty years as an employee of WSH, he has never received corrective action or discipline and that a permanent demotion under the circumstances presented here, is too severe. Therefore, Appellant asks that his demotion be overturned.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. A willful violation presumes a deliberate act. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.5 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989). Flagrant misbehavior occurs when an employee evinces willful or wanton disregard of his/her employer's interest or standards of expected behavior. Harper v. WSU, PAB No. RULE-00-0040 (2002).

4.6 Appellant relied on his nursing staff to provide adequate care for the patients on the ward. In the case here, Ms. Brown failed to notify Appellant of the circumstances regarding T.W. Namely, that T.W. was confrontational and agitated, was refusing his medication and was refusing to consume food or water and that she had safety concerns for staff due to T.W.'s agitated state. As a result Ms. Brown's lack of communication, Appellant did not have knowledge regarding the circumstances on the ward. Therefore, he did not have an opportunity to evaluate T.W. nor to determine how to intervene in his care while ensuring the safety of staff.

4.7 Nonetheless, as a nursing supervisor, Appellant had a high level of responsibility and a duty to check on his staff and on the status of patients. Furthermore, noted in on Appellant's

performance evaluation was the requirement that he spend more time on his assigned wards assessing the care his subordinate staff gave to patients. Appellant failed to visit his assigned ward on September 26, therefore, he failed to provide adequate supervision and appropriate guidance to his nursing staff. As a result, he failed to ensure that patients on the ward received proper care.

4.8 Respondent has met its burden of proof that Appellant neglected his duty and violated agency expectations and standards when he failed to make his rounds on the ward September 26, 2001. However, Respondent has failed to prove that Appellant engaged in flagrant misbehavior or that his performance deficiency rose to the level of gross misconduct.

4.9 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances including the seriousness and circumstances of the offense. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Holladay v. Dep't of Veteran's Affairs, PAB No. D91-084 (1992).

4.10 Based on a totality of the proven facts and circumstances, discipline is warranted. However, the level of sanction imposed by Respondent is too severe in light of the mitigating factors presented. First, Appellant's performance evaluations noted that he needed to spend more time completing written reports in a timely manner, and his decision to complete paperwork was consistent with that directive. Second, Dr. Hill was on the ward on September 26, and he checked on patient T.W., and therefore, also held some responsibility to take measures to intervene in T.W.'s seclusion and care. Finally, Appellant is a 20-year employee with no history of either formal or informal discipline and no history of any prior deficiencies regarding his performance as a

supervisor. Therefore, he should be given an opportunity to improve his performance overseeing the wards and other nursing staff.

4.11 These mitigating circumstances not withstanding, we conclude that a significant reduction in salary is necessary to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Therefore, the appeal should be granted in part and the disciplinary sanction should be modified to a one-year, four-step reduction in salary.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Paul Vilja is granted in part and the disciplinary sanction is modified to a one-year, four-step reduction in salary beginning January 16, 2002.

DATED this _____ day of _____, 2003.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Walter T. Hubbard, Chair

_____
René Ewing, Member

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504
(360) 586-1481